BIG SKY WAIVER
NOTIFICATION OF TERMINATION

TO:	Name & Address	FROM:	Name, Address & Phone Number

You are being terminated effective _____from the Big Sky Waiver program due to:

- ☐ your written request
- ☐ nursing facility or hospital placement.
- ☐ your temporary placement has expired (temporary level of care authorization expired, one time service)
- ☐ you transitioned to: _____
  Another service area or service such as SDMI or Big Sky Bonanza option
- ☐ you moved out of state

If you were terminated for an adverse action, a Regional Program Officer (RPO) with Senior & Long Term Care must sign this form and send a formal termination letter. Legal Basis for Action : ARM 37.40.1426, 42 CFR Part 431 Subpart E

- ☐ adverse action due to:_____

_____

If you have any questions regarding this action or if there are additional facts relating to your circumstances which you have not reported, please contact your case manager. Your questions will be answered or a meeting can be arranged. **(PLEASE READ REVERSE SIDE OF THIS NOTICE FOR YOUR FAIR HEARING RIGHTS).**

_____ _____ _____
Name Case Management Team Date

_____ _____
Regional Program Officer Date

IMPORTANT

If you disagree with the determination stated on this front of this form, you may request a fair hearing before an Administrative Law Judge of the Office of Fair Hearings. You must request a fair hearing in writing or complete information below, sign and mail to address listed below.

Under certain circumstances you may continue to receive services during the period of your appeal. A request for continuation of services must be made prior to the date given in the notice of the change in, or termination of, your services. If you are interested in continuing to receive services during the period of your appeal, you must indicate in your request for a fair hearing.

A request for a fair hearing must be made in writing within 90 days of the mailing date of this notice. You may use the "Request for Fair Hearing" section below to make your request. A request for fair hearing must be directed to:

Department of Public Health and Human Services
Office of Fair Hearings
P. O. Box 202953
Helena, MT 59620

REQUEST FOR FAIR HEARING

I am requesting a continuation of benefits during the period of the appeal if eligible [ ] YES [ ] NO

I request a fair hearing for the following reasons: _____

_____

_____

_____

_____

_____

I have an attorney: [ ] YES [ ] NO My attorney's contact information (Name, Address & Phone Number) is:

_____

_____

_____

_____ _____ _____
Claimant or Authorized Representative Phone Date

Prior to the fair hearing, a Department representative will conduct an administrative review of the matters which you are appealing. The administrative review is an opportunity to informally present your case and for the Department to reconsider the matters that you are appealing.

The fair hearing is a process in which the parties formally present their legal arguments and evidence in support of their positions on the matters at issue. The decision of the Administrative Law Judge is made based on the evidence presented at the hearing and upon governing federal and state laws, regulations and policies. The decision of the Administrative Law Judge resolves the matters at issue and is binding upon the parties unless an appeal is made to state district court.